

INPATIENT OPERATIONS HANDBOOK



Inpatient Operations Handbook – Children’s Mental Health Services

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1. GENERAL OVERVIEW OF OPERATIONS

In 1995, the County of San Diego assumed the responsibility for Medi-Cal authorization and payment of the State Medi-Cal match for all medically necessary acute psychiatric inpatient hospital services for Medi-Cal beneficiaries within the County. This was the result of the State Department of Mental Health (DMH) requirement for consolidation of inpatient resources.

The San Diego County Mental Health Medi-Cal Managed Care Inpatient Consolidation consists of County and contractor-operated services. Contracts with private community-based agencies were developed to provide functions such as payment authorization, initial crisis consultation and transition team services. There are two Fee-for-Service hospitals in San Diego County that provide acute inpatient days for children and adolescents. They are Sharp Mesa Vista and Aurora Health Care. University of California San Diego, Child and Adolescent Psychiatry Service (CAPS) is a separately funded inpatient service provided through a County contract.

Reference to Title 9 in this manual is to the California Code of Regulations, Title 9, Chapter 11, Medi-Cal Specialty Mental Health Services.

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2. CRISIS NOTIFICATION

Crisis Notification services for children and adolescents are operated through the Emergency Screening Unit (ESU) seven (7) days a week, 24 hours per day. Fee-for-Service providers for children and adolescents are required to submit notification to the ESU on all Medi-Cal admissions, within 24 hours, by faxing the County Crisis Notification form, which is the preferred method, or by calling the ESU directly. Crisis notification for UCSD CAPS is performed by the ESU.

ESU: Fax: (619) 421-7186 Phone: (619) 421-6900
 730 Medical Center Court, Chula Vista, CA 91911

3. TRANSITIONAL SERVICES PROGRAM

The Transition Team, operated by New Alternatives, Inc. under contract to the County, is a multi-disciplinary service component designed to provide intensive support and coordination of clinical services for qualifying children and adolescents. The team provides specialized case management for children and adolescents who are, or have been, hospitalized. The most intensive services are for frequent users of inpatient services who are at risk of re-hospitalization.

Clinical staff provides coordination and linkage to community resources, brokering of specialized aftercare services, coordination of clinical services and intensive in-home support to facilitate the child’s transition back home and to prevent re-hospitalization. The hospital shall contact the Transitional Services Program by calling 619-491-0195, for those clients who are in need of case management services.

4. CLAIMS AND BILLING

A) Fee For Service Hospital Procedure

There is a TAR Manual that is distributed by the State Department of Mental Health. The most recent version is dated February 2005. This manual is most helpful in delineating directions regarding completing TARs. Please contact San Diego County Mental Health or State DMH for a copy of this handbook if you do not have the most recent version.

Treatment Authorization Review

The Mental Health Plan (MHP) must approve or deny all Treatment Authorization Request forms (TARs) for acute days or administrative days for all Medi-Cal patients.

In order to enter the initial patient information into the MHP’s management information system, an original TAR must be sent to United Behavioral Health (UBH). The TAR shall be sent within 14 days of discharge.

- 1) Patient’s name and identification number
- 2) Provider’s name and identification number
- 3) Point of Service (POS) machine strip or copy of website page to verify Medi-Cal eligibility with the County and to identify the type of Medi-Cal (Aid Code).
- 4) Physician Log

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TARS should be mailed to: United Behavioral Health
Attention: Child and Adolescent Care Advocate
3111 Camino Del Rio North
Suite 500
San Diego, CA 92108

Phone number: 619 641-6809

Fax number: 619 641-6802

To order TARs (Form 18-3) 800-541-5555 (EDS)

In San Diego County, determination for approval or denial of days is made through concurrent review for San Diego Medi-Cal beneficiaries or retrospectively if Medi-Cal determined during or after hospitalization (with no previous concurrent review) . Therefore, any reference from section 1850.215, Title 9 or Aid Paid Pending is not applicable. (Refer to Section 1850.215, Title 9 for additional information on Aid Paid Pending).

The following are Title 9 requirements for submission of TARs as they apply to San Diego County’s post discharge payment authorization. A separate TAR shall be submitted for each of the following:

- Discharge of a beneficiary, no later than fourteen (14) calendar days after discharge.
- Administrative day services requested for a beneficiary.
- Ninety-nine (99) calendar days of continuous service to a beneficiary if the hospital stay exceeds that period of time.

The TAR and daily medical records are reviewed. Reasons for denials are documented on each TAR and signed by the Physician Advisor (PA).

Within fourteen (14) calendar days of receipt from the provider, all completed and approved TARs are submitted to Electronic Data Systems (EDS) for payment processing via certified mail and a copy is forwarded to the provider. TARs referred to the PA for further review require copies of the medical records. The fourteen (14)-calendar day timeline begins when copies of the medical records are made available to the provider. *Please note that TARs require an original physician signature. TARs that are signed by a nurse for the physician or have a stamped signature will be denied by EDS. While EDS has previously accepted these TARs, their process has changed, and the new standard is consistent with the current requirements of the TARs manual distributed by the Department of Mental Health.

For TARs submitted for review after the time line specified above, the TAR and medical record must be presented along with an explanation of why the TAR is being presented late.

Payment Authorization Review

The Payment Authorization Review (PAR) team consists of psychiatric trained nurses (RNs) and Physician Advisors (PAs) who are Board certified child and adolescent psychiatrists. The PAR team reviews all Medi-Cal inpatient medical records for payment of acute inpatient hospital stays. The medical records are evaluated to determine approval or denial of days based on the following:

- 1) Documentation of medical necessity based on Title 9, Section 1820.205 and
- 2) Timeliness and appropriateness of care.

The PAR process is summarized as follows:

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- The PAR nurse performs on-site review of medical records for Medi-Cal patients who are currently admitted in contracted facilities.
- The provider’s Utilization Review (UR) staff presents to the PAR nurse a Treatment Authorization Request (TAR) form and a verification of Medi-Cal eligibility with the County to identify the type of Medi-Cal eligibility (Aid Code). The top portion of the TAR must be completed and signed by the provider and the responsible physician.
- The PAR nurse, on each subsequent review, will write comments in the County Medi-Cal Consultant box of the TAR form and may provide feedback to the hospital’s UR staff.
- After discharge, the provider must present the TAR and discharge record to the PAR nurse within 14 calendar days of the discharge date for final review.
- If medical necessity is determined by the PAR nurse for every day, the TAR is approved for final processing by completing the right hand side of the TAR labeled “For County Use Only”.
- If there is a question about approval, the PAR nurse requests a copy of the medical record to be submitted by the provider within seven (7) calendar days. The PAR nurse will then present the medical record and the TAR to the Physician Advisor for review. The Physician Advisor will make a decision to either approve or deny days based on medical necessity. The TAR is signed by the Physician Advisor and dated for final processing. Copies of TARs are faxed to the providers before being sent to Electronic Data Systems (EDS) for payment.

For days denied, the provider may choose to appeal by following the appeals procedure.

B) UCSD CAPS Procedure

Treatment Authorization Review

Treatment Authorization Review at UCSD CAPS is performed through Utilization Review Committee (URC). The URC designee reviews all medical records of publicly funded patients. The designee will review daily chart entries for medical necessity criteria on each assigned continued stay review date and log documented acuity criteria.

Within fourteen (14) calendar days post patient discharge, the URC designee will submit a payment authorization request for reimbursement to UBH’s designated Child/Adolescent Care Advocate. A separate payment authorization request will be submitted for each of the following:

- Discharge of a beneficiary, no later than fourteen (14) calendar days post discharge.
- Ninety-nine (99) calendar days of continuous service to a beneficiary.
- Administrative Day services requested for a beneficiary.

Payment Authorization Review

The payment authorization review process at UCSD CAPS is summarized as follows:

- Post patient discharge, the URC designee presents documentation of acuity review and a payment authorization request to UBH’s designated Child/Adolescent Care Advocate..
- If UBH’s Child/Adolescent Care Advocate does not find medical necessity in the documentation for a requested day, the medical record review will be referred to UBH’s Medical Director. The Medical Director will make the final decision to either approve or deny the requested days.

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- The completed payment authorization request form will then be returned to the URC designee and UCSD CAPS will enter the information into the MHP’s Electronic Data System (EDS).

For days denied, UCSD CAPS may choose to appeal by following the appeals procedure.

Medi-Cal Medical Necessity Criteria

Title 9 of the California Code of Regulations (Section 1820.205) specifies the following medical necessity criteria for admission to inpatient services:

A. The client must meet one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, Text Revision, published by the American Psychiatric Association (DSM-IV-TR):

- Pervasive Developmental Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Tic Disorders
- Elimination Disorders
- Cognitive Disorders (only Dementia with delusions, hallucinations or depressed mood)
- Substance-induced Disorders only with Psychotic, Mood or Anxiety Disorder
- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Dissociative Disorders
- Eating Disorders
- Intermittent Explosive Disorder
- Pyromania
- Adjustment Disorders
- Personality Disorders
- Other Disorders of Infancy, Childhood, or Adolescence Feeding and Eating Disorders of Infancy or Early Childhood.

B. The client must have both 1 and 2:

1. Cannot be safely treated at a lower level of care
2. Requires psychiatric inpatient hospital services, as a result of a mental disorder, due to either (a) or (b):
 - (a) Has symptoms or behaviors due to a mental disorder that (one of the following):
 - Represents a current danger to self or others, or significant property destruction
 - Prevents the client from providing for, or utilizing, food, clothing or shelter
 - Presents a severe risk to the client’s physical health
 - Represents a recent, significant deterioration in ability to function
 - (b) Requires admission for treatment and/or observation for one of the following which cannot safely be provided at a lower level of care:
 - Further psychiatric evaluation
 - Medication treatment
 - Specialized treatment

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Note: Substance abuse disorder and developmental disorder in absence of other mental illness does not meet Title 9 medical necessity criteria for acute inpatient admission.

Criteria for Continued Stay

In order for UBH Child/Adolescent Care Advocate to authorize reimbursement for continued stay in acute inpatient services, the client must continue to meet the Medi-Cal Medical Necessity Criteria noted for admission to inpatient services. Continued stay in an acute psychiatric inpatient hospital will only be reimbursed when a client experiences one of the following:

- Continued presence of admission reimbursement criteria indications for psychiatric inpatient hospital services as specified in Medi-Cal Medical Necessity Criteria,
- Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization,
- Presence of new indications, which meet admission reimbursement criteria, noted in Criteria A and B, and/or,
- Need for continued medical evaluation or treatment that can only be provided if the client remains in an acute psychiatric inpatient hospital unit.

5. ADMINISTRATIVE DAYS

Administrative days are defined in Title 9 as psychiatric inpatient hospital care provided when the client's stay at the hospital must be continued beyond needed acute treatment days due to a temporary lack of placement options at appropriate, non-acute treatment facilities.

During this time, provider must obtain weekly documentation from the appropriate placement agency regarding their placement efforts; i.e. Probation, San Diego County Mental Health Special Education Services (AB2726), Child Welfare Services, or San Diego and Imperial County Regional Center for the Developmentally Disabled. In accordance with Title 9, in order to meet the State standards to receive reimbursement for administrative days, five (5) placement contacts per week are required from the placement agency and are to include the following required elements:

- name of facility
- date of contact
- person contacted
- immediate availability of bed
- name and signature of person making the call

This information shall be documented and referenced in the medical record.

6. APPEALS

At times, providers may disagree with UBH regarding a clinical or administrative issue. Providers are encouraged to communicate any issue or concern regarding clinical decisions or claims and billing procedures with UBH directly. UBH is committed to responding in an objective and timely manner and will attempt to resolve the issue informally through direct discussion with a provider.

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However, if the problem is not resolved to the satisfaction of the provider, a formal appeal process is available. The provider has the right to access the provider appeal process at any time before, during or after the provider resolution process has begun or when the complaint concerns a denied or modified request for payment authorization. You may also contact the Chief and Program Monitor, Critical Care Services, at (619) 397-6901 with any issues to be resolved.

Level I – Mental Health Plan

The provider may request a Level I Appeal by submitting a written request to UBH for a review within ninety (90) calendar days of the date of receipt of a denial of payment. The provider must include, in writing, all relevant data, documents or comments that support the medical necessity for the provided services. This information is to include, but is not limited to, the following:

- Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos
- Clinical records supporting the existence of medical necessity, if at issue
- A summary of the reasons why the services should have been authorized
- Provider’s name, address and phone number
- Signature of authorized provider representative

This information should be mailed to:

UBH Utilization Management Department
3111 Camino Del Rio North
Suite 500
San Diego, CA 92108

UBH shall have 60 calendar days from its receipt of the appeal to inform the provider in writing of their decision and its basis. If UBH reverses the PAR team’s decision, the provider will be notified to submit a revised TAR/Payment Authorization Request. UBH has 14 calendar days from the receipt date of the provider’s revised TAR/Payment Authorization Request to authorize payment and to submit the TAR/Payment Authorization Request to Electronic Data Systems (EDS) for processing. If no basis is found for altering the PAR team’s decision, the provider shall be notified of its right to submit an appeal to the State Department of Mental Health when applicable. The appeal must be filed within thirty (30) calendar days of UBH’s written decision of denial or failure by UBH to respond.

If UBH does not respond within 60 calendar days, the appeal is denied and the provider retains the right to appeal directly to the State Department of Mental Health. If the provider chooses not to pursue appeal to Level II, the denied TAR/Payment Authorization Request will not be paid.

Level II – State Department of Mental Health

In the event that the denial of payment is upheld at the Level I Appeal, the provider is notified of the right to a Level II Appeal. A Level II Appeal is submitted to the State Department of Mental Health Hearing Officer. The appeal must be filed in writing, along with supporting documentation, within thirty (30) calendar days of UBH’s written notification of the Level I appeal decision.

The appeal and supporting documentation should be sent to:

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Hearing Officer
California State Department of Mental Health
1600 9th Street
Sacramento, CA 95814
(916) 654-3607

The State DMH Hearing Officer will notify UBH and the provider of its receipt of a request for appeal within seven (7) calendar days and ask for specific documentation supporting the MHP’s decision to deny payment.

UBH will submit the required documentation within twenty-one (21) calendar days of notification of the appeal or the State DMH shall find the appeal in favor of the provider.

The State DMH shall have sixty (60) days from the receipt of the MHP’s documentation to notify the provider and the MHP in writing of the decision and its basis.

If the State DMH does not respond within sixty (60) calendar days from the postmark date of the MHP’s documentation, the appeal shall be deemed upheld.

As of June 30, 2003, if the State DMH upholds the original decision to deny reimbursement, a review fee will be assessed to the provider (DMH Letter #03-07)

If the State DMH overturns a provider appeal, the provider is notified in writing with instructions to submit a new TAR/Payment Authorization Request to UBH. UBH has fourteen (14) calendar days from the receipt date of the provider’s new TAR/Payment Authorization Request to authorize payment and submit to Electronic Data Systems (EDS) for processing.

NOTE: The State DMH does not accept Level II Appeals for administrative days

7. QUALITY IMPROVEMENT

On an annual basis, the County Quality Improvement (QI) staff will conduct medical record reviews and site reviews. Medical records will be reviewed for quality of care, medical necessity, appropriateness of service, timeliness of the service provided and compliance with Title 9 and industry standard guidelines.

Site reviews will be conducted annually. Requirements are based on State standards for Medi-Cal certification.

On-site reviews shall occur during normal business hours with at least 72-hours prior notice, except that unannounced on-site reviews and requests for information may be made in those exceptional situations where arrangement of an appointment before hand is clearly not possible or clearly inappropriate to the nature of the intended visit.

Providers are required to adhere to all Title 9 and all DMH Letters and Notices including but not limited to:

DMH Letter 04-04, which hospitals are required to be providing EPSDT and TBS notices to individuals 18-21.

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Providers are required to conduct client satisfaction surveys.

Providers are required to adhere to County policy regarding Unusual Occurrences.

All contracted mental health providers are required to adhere to cultural competence standards. The QI staff will look for elements of cultural competence in program orientations, staffing, charting and/or trainings during medical record reviews and site reviews.

Reports Required

All LPS facilities are required by the State DMH to submit the following quarterly reports to County Mental Health Services Quality Improvement Unit, using the State forms included in the Appendix:

- Denial of Rights/Seclusion and Restraint (MH 308)—if there are no instances of denied rights in a quarter, hospitals must submit a report saying this.
- Quarterly Report on Involuntary Detentions (MH 3825) –not required for non LPS facilities
- Convulsive Treatment Administered—to include Outpatient ECTs.

These reports should be submitted to the QI Unit by the 15th day after the end of the quarter on the forms have been provided, both in hard copy and electronically.

Please note that because of HIPAA confidentiality requirements completed forms containing patient identifiers are not allowed to be electronically submitted. These reports can be mailed or faxed to the QI Unit confidential fax at (619)563-2795.

Quality of Care

When a quality of care concern is identified by a Payment Authorization Review (PAR) staff, a Managed Care Quality Review form will be initiated. A paragraph will briefly describe the PAR staff person’s concern regarding a quality of care issue. At this time, the PAR staff will request copies of the appropriate pages of the medical record in question to accompany the Quality Review form. Although PAR will be the principle observers of quality of care, referrals may be made by anyone in the SDMHS Managed Care System.

Process:

First Determination Review:

The quality review form and selected medical record will be sent to the Managed Care Physician Advisor (PA) who will begin the review within seven (7) days of the finding. If the PA finds a potential concern of a quality care issue, that will be cited on the Quality Review form including the PA’s rationale for the concern.

Administrative Review:

The quality review form will be forwarded to the Contract Monitor and to Children’s Mental Health Services Quality Improvement for concurrence by the Local Mental Health Director (LMHD), or designee. After Concurrence, the form will be sent to the Quality Improvement Committee via SDMHS Quality Improvement Program.

Notification to Facility and Practitioner:

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A formal letter of notification signed by the LMHD, or designee, will be sent to the facility administrator and practitioner. A copy of the letter will also be forwarded to the Quality Improvement Committee via SDMHS Quality Improvement Program.

Required Provider Response:

The facility and practitioner will have thirty (30) days to reply with an explanation or further documentation regarding the quality of care issue. The response will be sent to the SDMHS Quality Improvement Program for processing and referral to the Managed Care Quality Improvement committee.

Second Determination Review:

The response will be reviewed by appropriate members of the Managed Care Quality Improvement Committee. The Committee will make a determination on the resolution or confirmation of quality of care concerns.

Tracking of Acceptable Responses:

If the response is deemed as acceptable, any follow up or corrective action necessary will be tracked by the SDMHS Quality Improvement Program.

Notice of Confirmed Quality of Care Concerns:

If the quality of care concern remains unsolved, a level of risk will be determined by the Committee and the facility administrator and practitioner will be informed by registered mail, return receipt requested, through the office of the Local Mental Health Director.

Follow Up and Tracking:

Confirmed quality of care concerns will be monitored and data will be analyzed for patterns of care.

8. CENSUS REPORTING

Effective August 19, 1996, Fee-for-Service providers shall provide daily census information as required by Paragraph 1.12 of Exhibit B of the Provider Agreement pursuant to the following procedures:

1. Provider staff shall fax by 12:00 noon Monday through Friday, a list of names and social security numbers of all Medi-Cal patients in the hospital to Payment Authorization Review. The list shall be provided on the appropriate form. The list shall include all patients who were in the hospital as of 12:01 AM of that day. Patients who were admitted and discharged within a 24 hour period, and not present as of midnight, shall be included in the census list for the following day.
2. The faxed list shall be accompanied by the initial Treatment Authorization Request (TAR) form and a copy of the Point of Service (POS) machine strip for all new admissions.
3. The census list for Saturdays and Sundays shall be faxed by 12:00 noon Monday with Monday’s census list.

UCSD CAPS census reporting is performed by the ESU.

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9. BENEFICIARY RIGHTS

San Diego County Mental Health is committed to protecting client’s rights in accordance with State and Federal Regulations and County policy. Violations of clients right’s will be responded to appropriately.

Confidentiality

Maintaining the confidentiality of client and family information is of vital importance, not only to meet legal mandates, but also as a fundamental trust inherent in the sensitive nature of the services provided through the MHP.

Client Guide

Providers are required to give each client a Client Guide at the client's admission, or upon request. The guide is entitled: County of San Diego, Guide to Medi-Cal Mental Health Services. The beneficiary guide contains a description of the services available through the MHP, a description of the required process for obtaining services, a description of the MHP problem resolution process, including the complaint resolution and grievance and appeal processes and a description of the beneficiary's right to request a State fair hearing. Guides are written by County Quality Improvement Department and distributed by Strategic and Administration Unit. Additional copies may be obtained by calling (619) 563-2788.

All patients must receive a copy of the State Handbook, “Rights for Individuals in Mental Health Facilities” or "Mental Health Minor's Rights: Handbook of Rights for Individuals in Mental Health Facilities". The handbooks deal with rights of persons both voluntarily and involuntarily admitted, discussing the role of the Patient Rights Advocate, rights that cannot be denied, rights that can be denied with good cause, medical treatment and the right to refuse it, and informed consent for medication. The County MHS contracts with the USD Patient Advocacy Program to assist patients with grievances and appeals. The Patient Advocate Program distributes an informing brochure for patients called “Seclusion & Restraint: Answers to Your Questions”.

Translation Service Availability

According to Title 9 and Title IV, Civil Rights Act of 1964, interpreter services shall be available to beneficiaries and families in threshold and non-threshold languages if requested or if the need is determined to assist in the delivery of specialty mental health services. It is not the standard of practice to rely on family members for translation services.

Client Grievances and Appeals

Clients may contact USD Patient Advocacy at 1-800-479-2233, if they are dissatisfied with any aspect of inpatient services they receive under the MHP.

It is the provider's responsibility to inform clients regarding their right to file a grievance or an appeal to express dissatisfaction with MHP services without negative consequences of any kind. Providers are required by Title 9 to post Grievance and Appeal posters (in English, Spanish, Vietnamese, Arabic, and Tagalog) in the hall or other visible area to ensure clients are advised of

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their rights. Title 9 requires that all providers ensure that these brochures are available to both clients and provider staff without the need of a verbal or written request by the client. Copies of the Grievance and Appeal posters and brochures may be obtained by contacting Strategic Planning & Administration Unit at (619) 563-2788. Inpatient providers are required by Title 9 to maintain a log in which all client or family concerns or grievances are entered. Concerns may be expressed verbally or in writing. The log must include the following elements:

- Complainant’s name
- Date the grievance was received
- Name of person logging the grievance
- Nature of the grievance
- Nature of the grievance resolution
- Date of resolution
-

The MHP may request a copy of a provider’s Grievance Log at any time.

Client Right To Request A State Fair Hearing

Clients have the right to request a fair hearing any time before, during or within 90 days after the completion of the beneficiary problem resolution process, whether or not the client uses the problem resolution process and whether or not the client has received a Notice of Action. Providers are required to inform their clients or the clients’ conservators/legal guardians of these rights.

Client Right To Have An Advance Health Care Directive

All new clients must be provided with the information regarding the right to have an Advance Health Care Directive at their first face-to-face contact for services. This procedure applies to emancipated minors and clients 18 years and older. Generally, Advance Directives address how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for themselves. The MHP provides an informational brochure on Advance Directives, available in the threshold languages, and copies may be obtained through the MHP Strategic Planning & Administration Unit by calling (619) 563-2788.

Glossary

Beneficiary

Any person certified as eligible under the Medi-Cal Program according to Section 51001, Title 22, California Code of Regulations.

Consolidation

The term used by the state to describe shifting Medicaid dollars to the local (County) level for capitation and distribution.

Contract Hospital

A provider of psychiatric inpatient hospital services, which is certified by the State Department of Health Services, and has a contract with a specific Mental Health Plan to provide Medi-Cal psychiatric inpatient hospital services to eligible beneficiaries.

County of Beneficiary

The county which currently is responsible for determining eligibility for Medi-Cal applicants or beneficiaries in accordance with Section 50120, Title 22, California Code of Regulations.

Fee For Service Medi-Cal (FFS/MC)

California’s Medi-Cal program that provides reimbursement on a per procedure basis for a broad array of health and limited mental health services provided to individuals who are eligible for Medi-Cal.

Fiscal Intermediary

The entity which has contracted with the State Department of Health Services to perform services for the Medi-Cal program pursuant to Section 14104.3 of the Welfare and Institutions Code.

Gatekeeper

Term for an organizational function which:

- Coordinates and assesses patient services needs
- Monitors services rendered to assure that only needed services are provided
- Identifies health practices and behaviors of target populations
- Creates a fixed point of responsibility
- Reduces service overlap and redundancy

Hospital

An institution, including a psychiatric health facility, that meets the requirements of Section 51207, Title 22, California Code of Regulations.

Implementation Plan for Psychiatric Inpatient Hospital Services

A written description submitted to the State Department of Mental Health (DMH) by the Mental Health Plan (MHP), and approved by the DMH, which specifies the procedures which will be used by a prospective MHP to provide psychiatric inpatient hospital services.

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Inpatient Hospital Services

See Psychiatric Inpatient Hospital Services definition.

Lanterman-Petris-Short (LPS)

Persons designated by San Diego County who may take or cause to be taken, mentally disordered person(s) into custody and place him/her in a facility designated by the County and approved by the State DMH as a Facility for 72-hour Treatment and Evaluation.

Local Mental Health Care Plan (PLAN)

The term used to denote the local managed mental health care plan administrator. The Plans will be responsible for offering an array of mental health services to all eligible Medi-Cal beneficiaries.

Managed Care

A new paradigm funding approach that combines clinical services and administrative methods in an integrated and coordinated way to provide timely access to care in a cost effective manner. Emphasis on prevention and early care reduce usage of more expensive methods of treatment.

Medi-Cal

California’s Medicaid Program

Medically Necessary

A service or treatment that is appropriate and consistent with diagnosis, and that, in accordance with accepted standards of practice in the mental health community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member’s condition or the quality of care rendered.

Mental Health Carve Out

It has been determined at the state level that the local County Mental Health Departments will design and develop a managed mental health care system separate from the local County Departments of Health. However, a clear mental health and health interface for integrating service delivery must be included in the design.

Mental Health Plan (MHP)

An entity which enters into an agreement with the State DMH to provide beneficiaries with psychiatric inpatient hospital services. An MHP may be a county, counties acting jointly or another governmental or non-governmental entity.

MHP Authorization for Payment

The initial process in which reimbursement for services provided by an acute psychiatric inpatient hospital to a beneficiary is authorized in writing by the MHP. In addition to the MHP authorization for payment, the claim must meet additional Medi-Cal requirements prior to payment.

Provider

A hospital, whether a Fee For Service/Medi-Cal or a Short Doyle/Medi-Cal provider, which provides psychiatric inpatient hospital services to beneficiaries.

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Psychiatric Inpatient Hospital Services

Both acute psychiatric inpatient hospital services and administrative day services provided in a general acute care hospital, a free standing psychiatric hospital or a psychiatric health facility that is certified as a hospital. A free standing psychiatric hospital or psychiatric health facility that is larger than sixteen (16) beds may only be reimbursed for beneficiaries 65 years of age and over and for persons under 21 years of age. If the person was receiving such services prior to his/her twenty-first birthday and he/she continues without interruption to require and receive such services, the eligibility for services continues to the date he/she no longer requires such services or, if earlier, his/her twenty second birthday.

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APPENDIX #2

Mental Health Websites

The following websites can be accessed for additional information:

County of San Diego, Health & Human Services Agency:

<http://www.co.san-diego.ca.us>

State of California Department of Mental Health:

<http://www.dmh.cahwnet.gov>

Medi-Cal Website:

<http://www.medi-cal.ca.gov>

United Behavioral Health:

<http://www.ubhpublicsector.com/sandiego/sdindex.htm>

Network of Care:

<http://networkofcare.org/home.cfm>

State of California Office of Patient Advocate:

<http://www.opa.ca.gov>

State of California Department of Managed Health Care:

<http://www.dmhca.gov>

National Alliance of Mentally Ill:

<http://www.nami.org>

Healthy Families:

<http://www.healthyfamilies.ca.gov>

Children’s Hospital and Health Center:

<http://www.chsd.org>

ARC of San Diego

<http://www.arc-sd.com>

LPS QUARTERLY REPORT FORMS

The following forms are attached for your reference. Instructions and restrictions are included.

A. DENIAL OF RIGHTS/SECLUSIONS AND RESTRAINT MONTHLY REPORT

Pages 18-19

B. QUARTERLY REPORT ON INVOLUNTARY DETENTIONS

Pages 20-22

C. CONVULSIVE TREATMENTS ADMINISTERED – QUARTERLY REPORT

Pages 23-25